Group Personal Accident Certificate

ZURICH AMERICAN INSURANCE COMPANY
1299 Zurich Way
Schaumburg, Illinois 60196

This is a summary of the insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of **Eligible Persons** described in Section I - Schedule of Benefits and Coverages and if the required premiums are paid when due.

THIS INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY. THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN.

PLEASE READ THIS CERTIFICATE CAREFULLY.

POLICYHOLDER: State of Wisconsin Group Insurance Board
801 West Badger Road
Madison, WI 53703

POLICY NUMBER: GPA 0214266

POLICY INCEPTION: January 1, 2017

POLICY PERIOD: January 1, 2019 to Continuous
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** Address)

Coverage Effective Date: January 1, 2019

PREMIUM: Payable Monthly

Plan 1:

Contributory (General Occupation) Rate per Month:	
Description	**Accidental Death/ Catastrophic Injury Coverage Cost Per $1,000 of Principal Sum**
Employee Only:	$00.026
Active Employee & Dependents:	$00.036

Contributory (Protective Occupation) Rate per Month	
Description	**Accidental Death/Catastrophic Injury Coverage Cost Per $1,000 of Principal Sum**
Employee Only:	$00.044
Active Employee & Dependents:	$00.060

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SECTION I – SCHEDULE

A. CLASSIFICATION AND ELIGIBILITY

1. Classification of Covered Persons

The following individuals are eligible to become **Covered Persons**:

Class I: An **active** Employee who is eligible for the State-sponsored health insurance plan, with or without Employer contribution.

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

2. Eligibility

The following individuals are eligible to become **Covered Persons** as set forth above upon submission of completed enrollment material, if required:

Not Applicable

Eligibility of **Your Dependents**:

Dependent Child(ren) of a Class I **Eligible Persons** are eligible to become **Covered Persons** if a parent becomes an **Insured**.

Spouse of Class I **Eligible Persons** are eligible to become **Covered Persons** if the **Eligible Person** becomes an **Insured**. Such **Spouse** must be under age 70.

A legally married **Spouse** will not be eligible for coverage as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your** legally married **Spouse**, legally separated **Spouse**, or former **Spouse** are both **Insureds** under the **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

B. REPORTING AND NOTICE ADDRESS(ES)

Claim Reporting:

Zurich American Insurance Company
P.O. Box 968041
Schaumburg, IL 60196-8041
Fax #: 866.255.2962
Phone #: 877.287.4805

C. SCHEDULE OF HAZARDS, COVERAGES AND BENEFITS

Plan 1

HAZARDS applicable to Class I **Contributory**:

Hazard
H-1 24 Hour Accident Protection

COVERAGES applicable to Class I **Contributory**:

Coverage	Benefit Amount
C-3 Accidental Death/Catastrophic Injury Coverage:	
Accidental Death Benefit	**Principal Sum** three or five times base annual salary up to a maximum of $500,000 as set forth in the **Principal Sum** Schedule.
Accidental Dismemberment and Covered Loss of Use Benefit	**Covered Loss** of: 1. Both Hands or Both Feet: 100% of the **Principal Sum** 2. One Hand and One Foot: 100% of the **Principal Sum** 3. One Hand or One Foot plus the loss of Sight of One Eye: 100% of the **Principal Sum** 4. Sight of Both Eyes: 100% of the **Principal Sum** 5. Speech and Hearing in Both Ears: 100% of the **Principal Sum** 6. Speech or Hearing in Both Ears: 50% of the **Principal Sum** 7. One Hand; One Foot; or Sight of One Eye: 50% of the **Principal Sum** 8. Thumb and Index Finger of the Same Hand: 25% of the **Principal Sum** **Covered Loss of Use** of: 1. Four **Limbs**: 150% of the **Principal Sum** 2. Three **Limbs**: 75% of the **Principal Sum** 3. Two **Limbs**: 66 2/3% of the **Principal Sum** 4. One **Limb**: 50% of the **Principal Sum**
Accidental Dismemberment and Covered Loss of Use Benefit for Eligible Dependent Child(ren)	**Covered Loss of:** 1. Both Hands or Both Feet: 100% of the Insured's **Principal Sum** to a maximum of $50,000 2. One Hand and One Foot: 100% of the Insured's **Principal Sum** to a maximum of $50,000 3. One Hand or One Foot plus the loss of Sight of One Eye: 100% of the Insured's **Principal Sum** to a maximum of $50,000 4. Sight of Both Eyes: 100% of the Insured's **Principal Sum** to a maximum of $50,000 5. Speech and Hearing in Both Ears: 100% of the Insured's **Principal Sum** to a maximum of $50,000 6. Speech or Hearing in Both Ears: 50% of the Insured's **Principal Sum** to a maximum of $25,000 7. One Hand; One Foot; or Sight of One Eye: 50% of the Insured's **Principal Sum** to a maximum of $25,000 8. Thumb and Index Finger of the Same Hand: 25% of the Insured's **Principal Sum** to a maximum of $25,000

Coverage	Benefit Amount
	Covered Loss of Use of: 1. Four Limbs: 150% of the Insured's **Principal Sum** to a maximum of $75,000 2. Three Limbs: 75% of the Insured's **Principal Sum** to a maximum of $37,500 3. Two Limbs: 66.67% of the Insured's **Principal Sum** to a maximum of $33,335 4. One Limb: 50% of the Insured's **Principal Sum** to a maximum of $25,000
Coma Benefit	1% of the **Covered Person's Principal Sum** per month for the first twelve (12) months and the remaining **Principal Sum** after the Monthly Benefit Period during which the **Covered Person** remains in a **Coma**.
Critical Burn Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Covered Person's Principal Sum**; or 2. 2. $25,000.
C-4 Accident Disability Coverage:	
Permanent and Total Disability Benefit	1% of the **Insured's Principal Sum** per month up to a maximum one-hundred (100) months.

Additional Benefits Schedule applicable to Class I (including **Insured's Dependents**) **Contributory** (Please refer to the Benefit Rider for details):

Additional Benefit	Benefit Amount
Carjacking Benefit	10% of the applicable **Principal Sum** for the **Covered Person** to a maximum of $50,000.
Continuation of Insurance Benefit	Period of Continuation: twelve (12) months.
Day Care Benefit	The maximum amount payable will be the lesser of: 1. 3% of the **Covered Person's Principal Sum**; or 2. $5,000.
Exposure and Disappearance Benefit	100% of the **Covered Person's Principal Sum**
Felony Victim Benefit	20% of the **Covered Person's Principal Sum**.
Hearing Aid or Prosthetic Appliance Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Covered Person's Principal Sum**; or 2. $15,000.
Higher Education Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Insured's Principal Sum**; or 2. $50,000; up to $200,000 per covered **Dependent Child**. Non-Qualified **Dependent Children** Benefit $1,000.
Home Alteration and Vehicle Modification Benefit	The maximum amount payable will be the lesser of: 1. 10% **Covered Person's Principal Sum**; or 2. $50,000.

Natural Disaster Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Covered Person's Principal Sum**; or 2. $50,000.
Occupational Hepatitis Accident Benefit	Equal to 20% of the **Insured's Principal Sum** at the date of the **Accident** up to a maximum of $100,000 not to exceed $4,167 in twenty-four (24) equal monthly installments.
Occupational HIV Accident Benefit	Equal to 20% of the **Insured's Principal Sum** at the date of the **Accident** up to a maximum of $100,000 not to exceed $4,167 in twenty-four (24) equal monthly installments.
Reserve Corps/National Guard Unit Benefit	100% of **Insured's Principal Sum**
Rehabilitation Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Insured's Principal Sum**; or 2. $50,000.
Seat Belt/Air Bag Benefit	Seat Belt Benefit – 10% of the **Covered Person's Principal Sum** up to a maximum of $50,000. Air Bag Benefit – 10% of the **Covered Person's Principal Sum** up to a maximum of $50,000.
Spouse Retraining Benefit	The maximum amount payable will be the lesser of: 1. 5% of the **Insured's Principal Sum**; or 2. $25,000.
Surviving Spouse Benefit	The monthly benefit will be equal to 1% of the **Insured's Principal Sum** and will be paid for a period of twelve (12) months.
Terrorism Benefit	The maximum amount payable will be the lesser of: 1. 10% of the **Covered Person's Principal Sum;** or 2. 2. $50,000.
Therapeutic Counseling Benefit	The maximum amount payable will be the lesser of: 1. the actual cost of the therapeutic counseling; or 2. 2. $2,500 for any one **Accident**.
Travel Assistance Benefit	Medical Evacuation Medical Repatriation Non-Medical Repatriation Return of Remains Visit to Hospital Return of Child Return of Companion
Waiver of Premium Option Benefit	Please refer to the attached benefit rider.

D. Principal Sum Schedule

Class I

Contributory: An **Active Employee** may purchase an amount of **Principal Sum** up to a maximum of $500,000 in increments Three (3) or Five (5) times the **Active Employee's Base Annual Earnings**.

The **Principal Sum** for covered **Dependents** will be a percentage of the **Insured's Principal Sum**, on the date of **Accident**, which is determined by multiplying **Your Principal Sum** by the percentage below.

Plan Selected	**% Spouse**	**% Child(ren)**
Spouse only:	60%	0%
Dependent Child(ren) only:	0%	20%
Spouse and **Dependent Child(ren)**:	50%	15%

Maximum of $300,000 **Principal Sum** Accidental Death Benefit for **Spouse**.

Maximum of $50,000 **Principal Sum** Accidental Death Benefit for **Dependent Child(ren)**.

In no event will the amount be greater than the **Insured's Principal Sum**.

At age seventy (70), the **Principal Sum** for the Accidental Death Benefit will be reduced based on the **Covered Person's** previous **Principal Sum** per the following schedule:

Age at Date of Loss	Percent of Previous **Principal Sum**
70 – 74	65%
75 – 79	45%
80 – 84	30%
85 & Over	15%

E. Premium Rate:

Enrollment Required: ☒ Yes ☐ No

Plan 1:

Contributory (General Occupation) Rate per Month:	
Description	**Accidental Death/ Catastrophic Injury Coverage Cost Per $1,000 of Principal Sum**
Employee Only:	$00.026
Active Employee & Dependents	$00.036

Contributory (Protective Occupation) Rate per Month	
Description	**Accidental Death/Catastrophic Injury Coverage Cost Per $1,000 of Principal Sum**
Employee Only:	$00.044
Active Employee & Dependents:	$00.060

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

Your Effective Date of **Contributory** Insurance:

A. For **Eligible Persons** hired prior to January 1 2019:

January 1, 2019, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For **Eligible Persons** hired on or after January 1, 2019:

the date defined under the **Policyholder's** written procedures as on file and approved by **Us**, following completion of the required **Service Waiting Period** indicated above, if any, provided the completed enrollment material is received by the **Policyholder** prior thereto.

Enrollment:

An **Eligible Person** may enroll for coverage under the **Policy** by making written or electronic application for coverage on an enrollment form furnished or approved by **Us**. Coverage will not become effective until the **Eligible Person** has enrolled himself or herself and his or her eligible **Dependents** and paid the required premium, if any.

Initial Enrollment: **Eligible Persons** should enroll themselves and their eligible **Dependents** within the number of days defined under the **Policyholder's** written procedures as on file and approved by **Us** or thirty one (31) days of the first of the following to occur:

1. the date first eligible as set forth in the Schedule; or
2. the date that the **Service Waiting Period** is satisfied if applicable to their eligibility Class.

Individuals who enroll after this time are considered Late Entrants.

Open Enrollment Period: **Eligible Persons** may enroll themselves and their eligible **Dependents** during an Open Enrollment Period. Other changes including increases, decreases or terminations may also be restricted to Open Enrollment Periods.

Late Entrants: **Eligible Persons** who do not enroll themselves or their eligible **Dependents** within their Initial Enrollment Period, may not enroll until the next Open Enrollment Period unless there is a Change in Family Status, as described below.

Change in Family Status: An **Eligible Person** may enroll or **You** may change **Your** coverage if a change in family status occurs, provided written or electronic application to enroll is made within the number of days defined under the **Policyholder's** written procedures as on file and approved by **Us** or thirty one (31) day(s) of the event. A change in family status means any of the following events:

1. marriage;
2. divorce or legal separation;
3. birth or adoption of a **Dependent Child(ren)**;
4. death of a **Spouse** or **Dependent Child(ren)**; or
5. other changes as permitted by the **Policyholder**.

SECTION III – DEFINITIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

Active and **Actively at Work** means an employee, member or individual who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Active** and **Actively at Work** provided the employee, member or individual is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.

Active Employee means any natural person in the regular service of the **Policyholder** and in the ordinary course of the **Policyholder's** business as defined by the **Policyholder**.

Air Travel Carrier means any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

1. medical certificate; and
2. pilot certificate with a proper rating to pilot such aircraft.

Base Annual Earnings means the **Active Employee's** base annual pay excluding overtime, bonuses, commissions and special compensation.

Certificate(s) means this Group Personal Accident Insurance Certificate.

Contributory means that **You** are required to pay all or a portion of the premium.

Common Carrier means:

1. any land or water conveyance licensed to carry persons for hire; or
2. **Air Travel Carrier**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an **Injury**, and for which benefits are payable under the **Policy**.

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You**, and **Your Spouse** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** and/or **Dependent Child(ren)** is selected.

Dependent means **Your Spouse** and **Dependent Child(ren)**, as defined in this section. The **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren) means those unmarried **Child(ren)** of the **Insured**, and those unmarried **Child(ren)** of his or her **Spouse**, and those unmarried **Child(ren)** as defined in the **Policyholder's** medical plan as on file and approved by **Us**. The **Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Eligible Person means an individual who:

1. is in an Eligible Class as described in the Classification and Eligibility part of SECTION I - SCHEDULE; and
2. has satisfied the **Service Waiting Period** as described in the Classification and Eligibility part of SECTION I - SCHEDULE, if any.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides twenty-four (24) hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

a. a nursing home, convalescent home, or skilled nursing facility;
b. a place of rest, custodial care, or for the aged;
c. a clinic; or
d. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

(1) part of the institution that meets the requirements in subparagraphs 1 - 4 above; and
(2) listed in the American Hospital Association Guide as a general **Hospital**.

Hospital Confined or **Hospital Confinement (Hospitalization)** means a stay by the **Covered Person** confined to a bed in a **Hospital** for which a room charge is made. The **Hospital Confinement** must be on the advice of a **Physician**, it must be **Medically Necessary**, and the result of **Injuries** sustained in an **Accident** or for rehabilitative care and treatment for **Injuries** sustained in an **Accident**. **Hospital Confinement** also means the period of **Hospital Confinement** that starts while the **Policy** is in force. If the **Hospital Confinement** follows a previously covered **Hospital Confinement**, it will be deemed a continuation of the first **Hospital Confinement** unless (1) the later **Hospital Confinement** is the result of an entirely unrelated **Injury** or (2) the **Hospital Confinements** are separated by ninety (90) days or more. **Hospitalization** that begins prior to the end of one calendar year and continues into the next calendar year will be considered one **Hospital Confinement**.

Injury means a bodily injury caused directly by an **Accident**, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the **Covered Person's** Effective Date of coverage and while coverage is in force for the **Covered Person**.

Insured means an employee and a member who is eligible for coverage under the **Policy** as provided in the Classification and Eligibility part of SECTION I - SCHEDULE, and who completes the enrollment material, if required.

Medically Necessary means a medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Injury** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

Member means a person or organization approved as a member of the **Policyholder** under the governing documents (such as the declaration and bylaws) of the **Policyholder**.

Physician means a person who is:

1. a doctor of medicine, osteopathy, or psychology that **We** recognize or are required by law to recognize (other than a chiropractor);
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not **Related** to the **Covered Person** by blood or marriage.

Plan means the Hazards, Coverages and/or Benefits as set forth in the Schedule.

Policy means the Group Personal Accident Policy issued to the **Policyholder**.

Policyholder means the entity named on the face page of the **Policy**.

Principal Residence means the country of the legal domicile of the **Covered Person**.

Principal Sum means the amount of insurance applicable to the **Covered Person** as stated in the Principal Sum Schedule.

Related means a person who is a **Spouse**, an adult living in the same household, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Retiree means a former employee of the **Policyholder**:

1. whose age plus years of service equals at least sixty (60);
2. who has attained the normal retirement age;
3. who has completed at least five (5) of active full-time or part-time service with the **Policyholder**;
4. who is participating in a **Policyholder**-sponsored pension plan; or
5. who retired from the **Policyholder** immediately after the last day as an **Active Employee**.

Service Waiting Period means the continuous length of time **You** are required to be employed by or a member of the **Policyholder** prior to being covered under the **Policy**.

Spouse, if used in the **Policy**, means **Your** legally married **Spouse** under age seventy (70). A **Spouse** will only be a covered **Spouse** if a **Plan** covering **Your Spouse** is selected.

War or **Act of War** means the hostile contention by means of armed forces, carried on between nations, states, or rulers, or between citizens in the same nation or state.

We, **Us**, and **Our** refers to Zurich American Insurance Company.

You or **Your** means the **Insured** to whom a **Certificate** is issued.

SECTION IV – HAZARDS

Subject to all the terms, conditions, limitations, and exclusions set forth in the **Policy**, the Hazards are also subject to the following additional terms, conditions, limitations, and exclusions.

Hazard Limitations

Coverage for air travel is limited to a **Covered Loss** as set forth in each Hazard below, while the **Covered Person** while riding in or on, boarding or alighting from any **Air Travel Carrier**.

The Hazards insured against by the **Policy** are:

H-1 24 Hour Accident Protection Coverage

An **Injury** sustained by a **Covered Person** resulting in a **Covered Loss** during a trip anywhere in the world.

Additional Hazard Limitations:

For purposes of this hazard only, the following additional limitation applies:

Coverage for air travel is limited to a **Covered Loss** sustained by **Covered Person** as a passenger, pilot, operator, member of the crew or cabin attendant, during a trip while riding in or on, boarding, or alighting from:

1. an **Air Travel Carrier**; or
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of American or the Armed Forces of any foreign government.

SECTION V – COVERAGES

Coverages afforded and Benefits payable are based on the Hazards insured against as set forth in SECTION I - SCHEDULE.

C – 3 Accidental Death/Catastrophic Injury Coverage:

Accidental Death Benefit

If a **Covered Person** suffers an **Injury** resulting in a loss of life, **We** will pay the applicable **Principal Sum** as set forth in the Schedule. The death must occur within 365 days of the **Injury**.

Accidental Dismemberment and Covered Loss of Use Benefit

If a **Covered Person** suffers an **Injury** resulting in any of the following **Covered Losses**, **We** will pay the benefit amount set forth in the Schedule. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

For purposes of this benefit only:

Covered Loss means:

a. For a Foot or Hand, actual severance through or above an Ankle or Wrist Joint;
b. Actual severance through or above the Metacarpophalangeal Joint of a Thumb and or Index Finger;
c. Total and permanent loss of Sight;
d. Total and permanent loss of Speech;
e. Total and permanent loss of Hearing.

Covered Loss of Use means total or functional paralysis of a **Limb** or **Limbs**, which has continued for twelve (12) consecutive months and is determined by a **Physician** to be permanent, functional and irreversible.

Limb means an Arm or a Leg.

Proof of total or functional paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

Accidental Dismemberment and Covered Loss of Use Benefit for Eligible Dependent Children

If an eligible **Dependent Child(ren)** suffer(s) an **Injury** resulting in any of the **Covered Losses** listed in the Schedule, **We** will pay the benefit set forth in the Schedule. The **Covered Loss** must occur within 365 days of the **Accident**.

For purposes of this benefit only:

Covered Loss means:

a. For a Foot or Hand, actual severance through or above an Ankle or Wrist Joint;
b. Actual severance through or above the Metacarpophalangeal Joint of a Thumb and/or Index Finger;
c. Total and permanent loss of Sight;
d. Total and permanent loss of Speech;
e. Total and permanent loss of Hearing.

Covered Loss of Use means total or functional paralysis of a **Limb** or **Limbs**, which has continued for twelve (12) consecutive months and is determined by a **Physician** to be permanent, functional and irreversible. Proof of total or functional paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

Limb means an Arm or a Leg.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

Coma Benefit

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within fifteen (15) days of an **Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay the benefit amount set forth in the Schedule.

The Coma Benefit will be payable monthly as set forth in the Schedule, following the initial fifteen (15) day period. At the end of the Monthly Benefit Period, if the **Covered Person** remains in a **Coma**, **We** will pay a Lump Sum Payment equal to the maximum amount set forth in the Schedule payable under the Accidental Death Benefit less the amount of the monthly benefit already received. The Coma Benefit is equal to the maximum amount set forth in the Schedule and will be paid following the initial fifteen (15) day period.

For purposes of this benefit only, **Coma** means a continuous state of profound unconsciousness, diagnosed or treated after the **Covered Person's** Effective Date of coverage, lasting for a period of seven (7) or more consecutive days, and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. **Coma** does not include a medically induced coma.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

Critical Burn Benefit

If a **Covered Person** suffers an **Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of an **Accident**, **We** will pay a benefit as set forth in the Schedule provided:

1. the **Covered Person** received second degree or higher burns over at least 25% of his or her body; and
2. within 365 days of the **Accident**, the **Covered Person** has undergone reconstructive surgery to treat the burned areas of the body.

The Critical Burn Benefit is an amount equal to the least of:

1. the actual cost for the expense of the reconstructive surgery;
2. the amount resulting from multiplying the injured person's amount of **Principal Sum** by the percentage of **Critical Burn**; or
3. the Maximum Amount for this Benefit as provided in the Schedule.

For purposes of this benefit only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to an **Injury** that is a full-thickness or third-degree burn, as determined by a **Physician**. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

C – 4 Accident Disability Coverage:

Permanent and Total Disability Benefit

If **You** suffer an **Injury** that renders **You Permanently and Totally Disabled**, **We** will pay a Permanent and Total Disability Benefit provided that **You** become **Permanently and Totally Disabled** within 365 days of the **Injury** and only if the **Permanent and Total Disability** continues for twelve (12) consecutive months.

The monthly amount payable under this benefit will be the amount set forth in the Schedule. These payments will cease at the earlier of the time that:

1. **We** make the payments as set forth in the Schedule;
2. **You** are no longer **Permanently and Totally Disabled**; or
3. **You** die.

For purposes of this benefit only, the following additional definitions apply:

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**.

Permanent and Total Disability (Permanently and Totally Disabled) means disability that:

1. prevents **You** from performing the material and substantial duties of **Your** occupation, immediately prior to the **Accident**; and
2. requires the **Continuous Care** and treatment of a **Physician**.

If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for the Permanent and Total Disability Benefit. **You** shall not qualify for **Permanent and Total Disability** if **You** engage in any activity that results in earned income.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

SECTION VI – GENERAL EXCLUSIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. **War** or any **Act of War**, whether declared or undeclared;
3. involvement in any type of active military service. For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;

6. being legally intoxicated while operating a motorized vehicle.
   a. a **Covered Person** will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motorized vehicle.
   b. an autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication;
7. being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage and in accordance with drug interaction warnings;
8. travel or flight in any aircraft except to the extent stated in SECTION IV – HAZARDS and SECTION V – COVERAGES.

SECTION VII – GENERAL LIMITATIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

Limitation on Multiple Covered Losses. If a **Covered Person** suffers more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Coverages and Benefits. If a **Covered Person** suffers a **Covered Loss** which is payable under more than one benefit as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

Limitation on Multiple Hazards. If a **Covered Person** suffers a **Covered Loss** under more than one Hazard, **We** will pay only one benefit, the largest benefit.

SECTION VIII - TERMINATION OF INSURANCE

A. Termination of **Covered Person's** Insurance

You. Insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;
4. **You** retire.

Covered Person other than **You**. Insurance terminates on the earliest of:

1. the date the insurance for **You** terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**.

Conversion Privilege

Solely with respect to the Accidental Death/Catastrophic Injury Coverage, if the insurance under the **Policy** for **You** ceases for reasons other than termination or nonpayment of premium, **You** are entitled to convert **Your Policy** to an Individual Accidental Death or Dismemberment (IAD) policy or to a Family AD&D (FAD) policy if **You** selected a **Plan** covering **Your Dependents**. The new IAD or FAD or IMC policy will be issued on the standard forms issued by **Us** and will not include all the Benefits and Additional Benefits of the **Policy**. **You** must make a written application for the IAD or FAD or IMC policy within sixty (60) days of the cessation of insurance under the **Policy**. To request a Conversion Application Form, **You** must call 1-800-834-1959. **You** do not have to show proof of good health.

The issuance of the IAD or FAD policy is subject to the following conditions:

1. the **Principal Sum** for the IAD or FAD policy will be the lesser of **Your Principal Sum** under the **Policy** or $250,000 or subject to the limitations permitted by state law;
2. the premium for the IAD or FAD policy will be the rate on file with the proper regulatory authority, if such filing is required;

3. any IAD or FAD policy issued will take effect on the termination date of **Your** insurance under the **Policy**; and
4. when an IAD or FAD policy becomes effective, the relationship between **You** and **Us** will be governed by the terms and conditions of that policy, including benefits and termination dates.

The Conversion Privilege will cease when **You** attains age seventy (70).

SECTION IX - HOW TO FILE A CLAIM

A. Notice. **You** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the Policy Number. To request a claim form, **You** or the beneficiary, or someone on their behalf may contact **Us** at 1-866-391-6034. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

B. Claim Forms. **We** will send the claimant Proof of Covered Loss forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss Form in fifteen (15) days after submitting notice, **You** can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a proof of **Covered Loss**.

C. Proof of Loss. Written Proof of Loss must be sent to **Us** as soon as possible within one (1) year after the time of the **Covered Loss**. Failure to furnish Proof of Loss within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Loss, and the proof was provided as soon as reasonably possible.

SECTION X - PAYMENT OF CLAIMS

A. Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, as soon as **We** receive written Proof of Loss. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss**.

B. Who We Will Pay.

1. Loss of Life of an **Insured**. In the absence of a written designation of beneficiary, or if all designated beneficiaries who survive the decedent die before filing with the department a beneficiary designation applicable to that death benefit or an application for any death benefit payable, the person determined in the following sequence: group 1, surviving spouse; group 2, children of the deceased participant, employee or annuitant, in equal shares, with the share of any deceased child payable to the issue of the child or, if there is no surviving issue of a deceased child, to the other eligible children in this group or, if deceased, their issue; group 3, parent, in equal shares if both survive; group 4, brother and sister in equal shares and the issue of any deceased brother or sister. The shares payable to the issue of a person shall be determined per stirpes. No payment may be made to a person included in any group if there is a living person in any preceding group, and s. HYPERLINK "/document/statutes/854.04(6)"854.04 (6) shall not apply to a determination under this subsection.
2. Loss of Life of a **Covered Person** other than the **Insured**. **Covered Losses** for the death of a **Covered Person** other than the **Insured** will be paid to the **Insured**. If the **Insured** pre-deceases or dies at the same time as the **Covered Person** other than the **Insured**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death.
3. All Other Claims. Benefits are to be paid to the **Covered Person**.

C. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

D. Choice of Service Provider. The **Covered Person** has the sole right to choose his or her **Physician** and **Hospital**.

SECTION XI - GENERAL POLICY CONDITIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

A. Beneficiaries. **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be submitted to **Us** in writing.

B. Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

C. Clerical Error. A clerical error or omission will not increase or continue **Your** Coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

D. Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

E. Time Limit on Certain Defenses. In the absence of fraud, statements made by the **Policyholder** or a **Covered Person** are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under the **Policy** or be used as a defense of a claim, unless it is contained in a signed written application. After two (2) years from the date coverage starts no such statement (except age) will cause the **Policy** to be contested.

Carjacking Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in a loss of life or **Covered Loss**, which is payable under the Accidental Death Benefit or the applicable Accidental Dismemberment Benefit, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the **Covered Person** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule.

Verification of the **Carjacking** must be made in an official police report within twenty-four (24) hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24) hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this rider only, the following additional definition applies:

Carjacking means a person other than the **Covered Person** taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knepper

January 1, 2019

President Date

Continuation of Insurance Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Spouse** and **Dependent Child(ren)** and the **Insured** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, all Coverages, Benefits and Additional Benefits under this **Policy**, which were in force for such **Spouse** and **Dependent Child(ren)** on the date of death, will be continued automatically for the period set forth in the Additional Benefits Schedule.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knupfer

January 1, 2019

President Date

Day Care Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her **Spouse** suffers an **Injury** resulting in a loss of life, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule for day care expenses to the individual who incurs the expense on behalf of each **Dependent Child** if, on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility** or enrolls in such facility within thirty (30) days from the date of death of the **Insured** or his or her **Spouse**.

If the **Insured** and his or her **Spouse** both die as a result of the same **Accident**, and **We** pay an Accidental Death Benefit on both **Covered Persons**, the **Insured's Principal Sum** will be used to calculate the amount applicable under this benefit.

The Day Care Benefit will be paid annually for ten (10) consecutive year(s) if **We** receive verification that the **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

For purposes of this rider only, the following additional definition applies:

Accredited Child Care Facility means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a **Hospital**, the **Dependent Child's** home, a nursing or convalescent home, a facility for the treatment of mental disorders, an orphanage or a treatment center for drug and alcohol abuse.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knepfer

January 1, 2019

President Date

Felony Victim Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in loss of life or **Covered Loss**, which is payable under the Accidental Death Benefit or the applicable Accidental Dismemberment Benefit as a result of a **Felony Crime** committed by someone other than the **Covered Person**, a **Fellow Employee** or a member of the **Covered Person's Family** or **Household**, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule.

For purposes of this rider only, the following additional definitions apply:

Family means the **Covered Person's** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild or person related to the **Covered Person**.

Fellow Employee means a person employed by the **Policyholder** or by an affiliate or subsidiary corporation of the **Policyholder**. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the crime or attempted crime was committed.

Felony Crime(s) means the following actual or attempted felony crimes of murder, robbery, battery, theft, assault, sexual assault or kidnapping.

Household means a person who maintains residence at the same address as the **Insured**.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark E. Knipfer

January 1, 2019

President Date

Hearing Aid or Prosthetic Appliance Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the applicable Accidental Dismemberment Benefit, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule provided:

1. the **Covered Person** is required to use a hearing aid or **Prosthetic Appliance**;
2. the **Injury** that caused the payment of the applicable Accidental Dismemberment Benefit is the same **Injury** that requires the **Covered Person** to use the hearing aid or **Prosthetic Appliance**; and
3. the hearing aid or **Prosthetic Appliance** was required within one (1) year of the **Injury**.

The amount **We** will pay will be equal to the one-time cost of the hearing aid or **Prosthetic Appliance** actually paid by the **Covered Person**.

This benefit will not be paid unless:

1. the hearing aid or **Prosthetic Appliance** was prescribed by a **Physician**; and
2. proof of payment is provided to **Us**.

For purposes of this rider only, the following additional definition applies:

Prosthetic Appliance means a replacement or artificial substitution for a missing **Limb** or eye. This does not include a dental prosthetic device such as dentures or crowns.

The maximum amount payable under all provisions of this rider combined will be the amount set forth in the Additional Benefits Schedule.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knupfer

January 1, 2019

President Date

Higher Education Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Dependent Child(ren)** and the **Insured** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**.

A **Dependent Child** is eligible for the Higher Education Benefit if on the date of the death of the **Insured**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls as a full-time student in an accredited college, university or trade school within one (1) year from the date of death of the **Insured**.

The Higher Education Benefit will be the amount set forth in the Additional Benefits Schedule. This amount will be paid annually for four (4) consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof to **Us** that he or she is attending an accredited college, university or trade school on a full-time basis.

The maximum amount payable under this benefit is the amount set forth in the Additional Benefits Schedule.

If a **Plan** covering the **Insured's Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit (a “Non-Qualified Dependent”), **We** will pay an additional benefit as set forth in the Additional Benefits Schedule to the designated beneficiary.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knipfer

January 1, 2019

President Date

Home Alteration and Vehicle Modification Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Dependent Child(ren)** and the **Insured** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**.

A **Dependent Child** is eligible for the Higher Education Benefit if on the date of the death of the **Insured**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls as a full-time student in an accredited college, university or trade school within one (1) year from the date of death of the **Insured**.

The Higher Education Benefit will be the amount set forth in the Additional Benefits Schedule. This amount will be paid annually for four (4) consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof to **Us** that he or she is attending an accredited college, university or trade school on a full-time basis.

The maximum amount payable under this benefit is the amount set forth in the Additional Benefits Schedule.

If a **Plan** covering the **Insured's Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit (a “Non-Qualified Dependent”), **We** will pay an additional benefit as set forth in the Additional Benefits Schedule to the designated beneficiary.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knipfer

January 1, 2019

President Date

Natural Disaster Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in a loss or life, as a direct result of a **Natural Disaster**, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule.

For purposes of this rider only, the following additional definition applies:

Natural Disaster means a weather event such as a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event, that arises from natural causes without direct human involvement and results in severe and widespread damage.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knipfer

January 1, 2019

President Date

Occupational Hepatitis Accident Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers an **Injury** directly caused by an **Occupational Accident** that results in in a **Covered Loss** which causes him or her to acquire and test positive for **Hepatitis** within 365 days of such **Occupational Accident**, **We** will pay an Occupational Hepatitis Accident Benefit as set forth in the Additional Benefits Schedule provided the **Insured** submits:

1. a workers compensation injury report to the **Policyholder** within forty-eight (48) hours of the **Accident**. If the **Policyholder** does not maintain workers compensation insurance, the **Insured** must report the **Accident** to the **Policyholder** within forty-eight (48) hours of the **Accident**. The **Policyholder** must submit an accident report approved by **Us** within ten (10) business days of the **Accident**; and
2. to a Food and Drug Administration (FDA) approved preliminary screening test for **Hepatitis** resulting in a positive finding with respect for the presence of any antibodies or antigens to such disease. **We** must receive written notification of the test results from the laboratory which performed the test as soon as reasonably possible.

If the initial finding is negative, and the **Insured** subsequently tests positive for **Hepatitis** antigens or antibodies within 365 days of the **Occupational Accident**, **We** will begin monthly payments on the first of the month following receipt of the report indicating a positive finding.

For purposes of this rider only, the following additional definitions apply:

Hepatitis means inflammation of the liver caused by a virus or a toxin. **Hepatitis** includes Hepatitis B, C, D and E.

Occupational Accident means an **Accident** resulting in exposure to **Hepatitis** which occurs while the **Insured** is performing job related duties for the **Policyholder**. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark E. Knopfer

January 1, 2019

President Date

Occupational HIV Accident Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers an **Injury** resulting in a **Covered Loss** while performing his or her job related duties for the **Policyholder**, which causes him or her to acquire and test positive for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC) within 365 days of such **Accident**, **We** will pay an Occupational HIV Accident Benefit as set forth in the Additional Benefits Schedule provided the **Insured** submits:

1. a workers compensation injury report to the **Policyholder** within forty-eight (48) hours of the **Accident**. If the **Policyholder** does not maintain workers compensation insurance, the **Insured** must report the **Accident** to the **Policyholder** within forty-eight (48) hours of the **Accident**. The **Policyholder** must submit an accident report approved by **Us** within ten (10) business days of the **Accident**; and
2. to a blood test for HIV and/or AIDS and/or related complex (ARC) within forty-eight (48) hours of the **Accident**, which is administered by a **Physician**. **We** must receive written notification of the test results from the laboratory which performed the test as soon as reasonably possible.

If the initial test is negative, and the **Insured** subsequently tests positive for HIV, AIDS or ARC within 365 days of the **Accident**, **We** will begin monthly payments on the first of the month following receipt of the report indicating positive test results.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knupfer

January 1, 2019

President Date

Rehabilitation Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers an **Injury** resulting in a **Covered Loss** which is payable under the applicable Accidental Dismemberment Benefit, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred by the **Insured** for **Rehabilitation Training** as set forth in the Additional Benefits Schedule.

For purposes of this rider only, the following additional definitions apply:

Rehabilitation Training means a treatment program that:

1. is prescribed by a **Physician** prior to the provision of services;
2. is required due to the **Insured's Injury**; and
3. prepares the **Insured** for the same occupation or an occupation that he or she would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knipfer

January 1, 2019

President Date

Reserve Corps/National Guard Unit Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers an **Injury** resulting in a loss of life or **Covered Loss**, which is payable under the Accidental Death Benefit or applicable Accidental Dismemberment Benefit, while the **Insured** is a Ready Reserve or Standby Reserve member of an organized State Reserve Corps, State Militia, or National Guard Unit and the **Insured** is:

1. attending any regularly scheduled or routine training of less than sixty (60) days, or the **Insured** is en route to or from such training;
2. attending a **Service School** or the **Insured** is en route to or from such **Service School**;
3. taking part in a muster required by a State Reserve Corp, State Militia or National Guard Unit while on inactive duty; or
4. taking part as a unit member in a parade or exhibition authorized by official orders;

We will pay the applicable **Principal Sum** for such **Covered Loss**.

For purposes of this rider only, the following additional definition applies:

Service School means an educational facility operated by, or on behalf of, the United States of America, NATO (North Atlantic Treaty Organization), the United Nations, or Canada.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knupfer

January 1, 2019

President Date

Seat Belt/Air Bag Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, as a direct result of an automobile **Accident**, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule provided that the **Covered Person** was:

1. driving or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other proof submitted to **Us**.

An additional benefit as set forth in the Additional Benefit Schedule will be paid if the **Covered Person** was driving or riding as a passenger in a private passenger automobile with a manufacturer equipped air bags, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other proof submitted to **Us**.

For the purpose of this rider only, the following additional exclusions apply:

We will not pay a Seat Belt or Air Bag Benefit if the **Covered Person** was either the driver in an automobile where the driver was:

1. legally intoxicated;
   a. A driver will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the **Accident** occurred; or
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, narcotic, controlled substance or hallucinogen, unless such prescription drug, narcotic, controlled substance or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage and in accordance with drug interaction warnings.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

January 1, 2019

President Date

Spouse Retraining Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Spouse** and the **Insured** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, **We** will pay the amount set forth in the Additional Benefit Schedule to the **Insured's** covered **Spouse**, for the actual cost of any professional or trade-training program in which the covered **Spouse** enrolls, provided:

1. the purpose of the professional or trade-training program is to obtain an independent source of support and maintenance;
2. the professional or trade-training program is successfully completed within twenty-four (24) months from the death of the **Insured**; and
3. the professional or trade training program is licensed by the state.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark E. Knopfer

January 1, 2019

President Date

Surviving Spouse Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Spouse** and the **Insured** suffers an **Injury** resulting in a loss of life which is payable under the Accidental Death Benefit, **We** will pay an additional benefit to the **Insured's** covered **Spouse** as set forth in the Additional Benefits Schedule.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark G. Knipfer

January 1, 2019

President Date

Terrorism Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If a **Covered Person** suffers an **Injury** resulting in a loss of life or **Covered Loss**, which is payable under the Accidental Death Benefit or applicable Accidental Dismemberment Benefit, that was directly caused by an **Act of Terrorism**, **We** will pay an additional benefit as set forth in the Additional Benefits Schedule.

For purposes of this rider only, the following additional definition applies:

Act of Terrorism means any intentionally violent or forceful act anywhere in the world by any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

For purposes of this rider only, the following additional condition applies:

We may cancel this Terrorism Benefit by sending the **Policyholder**, at its most recent address in **Our** records, a ten (10) day notice of **Our** intent to cancel. Upon cancellation of this rider, **We** will return any unearned premium on a pro-rata basis that the **Policyholder** has paid, but this is not a condition of termination. A change or termination in this benefit will not affect a claim that begins while this benefit is in force. In the event of cancellation of this rider, the **Policyholder** is responsible for notifying all **Insureds**.

This benefit is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

January 1, 2019

President Date

Therapeutic Counseling Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her covered **Dependents** suffers an **Injury** resulting in [a loss of life or a **Covered Loss**, which is payable under the Accidental Death Benefit or applicable Accidental Dismemberment Benefit, and the **Insured** or his or her covered **Dependents** requires **Therapeutic Counseling**, **We** will reimburse the charges for such counseling, to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within ninety (90) days of the **Accident**; and
3. **Therapeutic Counseling** must be completed within one (1) year(s) from the date of the **Covered Loss**.

The maximum amount payable under this benefit is the amount set forth in the Additional Benefits Schedule for **Therapeutic Counseling** for any one **Accident**.

For purposes of this rider only, the following additional definition applies:

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

January 1, 2019

President Date

Travel Assistance Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

This Travel Assistance Benefit will apply to **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**. The transportation and/or services provided under this Travel Assistance Benefit must be pre-authorized by **Us**. Under this **Policy**, the Travel Assistance Benefit consists of the following:

Medical Evacuation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic, or by a medical provider which, based upon **Our** evaluation, cannot provide medical care which could treat the **Covered Person's** medical condition in accordance with generally accepted medical standards of the United States of America, Canada or Western Europe, **We** will arrange and pay the cost for the transport, including special personnel and/or equipment, of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for or covered without the prior recommendation of the attending **Physician**.

Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel with minimal risk to his or her health, such **Covered Person** shall be repatriated to his or her **Principal Residence** or to the country where he or she was assigned. **We** will arrange and pay the cost for the transport of the **Covered Person** on a non-scheduled commercial air flight or the additional reasonable expenses for the regularly scheduled air flight, including special personnel and/or equipment, if applicable. No transport will be arranged for or covered without the prior recommendation of the attending **Physician**. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. Paragraphs 3 and 4 under Travel Assistance Exclusions will not apply to this benefit.

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip**, and has to be repatriated to his or her **Principal Residence**, or to the country where he or she was assigned, due to the **Injury** or **Illness**, **We** will pay the reasonable additional expenses to change the original travel date on the return flight and/or an upgrade in the seating. **We** must be contacted prior to making the change to the original travel date and/or an upgrade in the seating and **We** must pre-authorize the transport for benefits to be payable. Paragraphs 3 and 4 under Travel Assistance Exclusions will not apply to this benefit.

Return of Remains

If a **Covered Person** dies while on a **Covered Trip**, **We** will make arrangements and pay the reasonable expenses for the local preparation of the body for transport (including cremation), travel clearances and authorizations, standard shipping container (including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transport, and **We** must pre-authorize the preparation and transport for benefits to be payable.

Visit to Hospital

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip**, **We** will arrange for, and pay the cost of, a regularly scheduled round trip economy class air flight and accommodations (including hotel/lodging and meals; but excluding personal comfort or convenience items) of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. **We** must pre-authorize the transportation for this Visit to Hospital Benefit to be payable.

Return of Child

If a **Covered Person** is traveling with a **Dependent Child(ren)**, who is under twenty-six (26) years of age or a **Dependent Child(ren)** who prior to age of twenty-six (26) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Covered Person** such **Dependent Child(ren)** was (were) left unattended, **We** will arrange and cover the cost of reasonable expenses to transport such **Dependent Child(ren**) to the location chosen by the **Covered Person**, including the reasonable expenses for an attendant, if applicable. **We** must be contacted prior to the transport, and **We** must pre-authorize the transport for benefits to be payable.

Return of Companion

If a **Covered Person** is traveling with a companion while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will arrange and pay the additional reasonable expenses to change the travel date of the companion's return flight. **We** must be contacted prior to making the change to the original travel date of the companion's return flight, and **We** must pre-authorize the transport for benefits to be payable.

For purposes of this rider only, the following additional definitions apply:

Covered Trip means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the Travel Assistance Exclusions in this rider.

Illness or **Ill** means a sickness or disease, which impairs normal functions of the body. **Illness**, as covered under this Travel Assistance Benefit is solely covered under this Travel Assistance Benefit, and in no way supersedes or modifies the other coverages provided under this **Policy**.

For purposes of this rider only, the following additional exclusions apply:

Travel Assistance Exclusions

We will not pay expenses if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the influence of any controlled substance, unless such controlled substance was prescribed by a **Physician** and was taken in accordance with the prescribed dosage and in accordance with drug interaction warnings;
3. based upon **Our** review of a claim, **We** determine that the medical care in the hospital, medical facility, or clinic or by the medical provider was and would have been in accordance with generally accepted medical standards of the United States of America, Canada or Western Europe;
4. based upon **Our** review of a claim, **We** determine that it was not **Medically Necessary** to transport the **Covered Person** to another hospital or medical facility;
5. the **Injuries** or **Illness** resulted in whole or in part from the **Covered Person** being intoxicated and operating a motorized vehicle. A **Covered Person** will be conclusively presumed to be intoxicated if on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed to be intoxicated if operating a motor vehicle in that jurisdiction. A report from a law enforcement officer, medical provider or similar report will be considered proof of the **Covered Person's** intoxication;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this benefit. **We** will be fully and completely excused from performance and discharged from any contractual obligation.

For purposes of this rider only, the following additional conditions apply:

Right of Recovery

We have the right to recover any benefits **We** have paid under this Travel Assistance Benefit if the **Covered Person** recovers any money from a third party for the expenses that were covered under this Travel Assistance Benefit. **We** will be reimbursed from such recovery, and **We** will have a lien against that recovery. **Our** right to recover under this provision is limited to the amount remaining after the **Covered Person** has been made whole.

Scope

Covered transportation expenses will be limited to air and marine conveyances.

This amount is not subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

January 1, 2019

President Date

Waiver of Premium Option Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers an **Injury** that renders the **Insured Totally Disabled** while covered under this **Policy**, **We** will waive the premium due for him or her under this **Policy**; provided the disability has continued for a period greater than twelve (12) consecutive months.

Premium payments must continue for the first twelve (12) month(s) of continuous **Total Disability**. However, credit toward the first twelve (12) month(s) of continuous **Total Disability** will be given if the **Insured** was **Totally Disabled** under the policy that **We** replaced. After this twelve (12) month period of continuous **Total Disability**, the **Insured's** premium for this **Policy** will be waived until the earliest of the following:

1. the **Insured** is no longer **Totally Disabled**;
2. the **Policy** terminates; or
3. the **Insured's** employment with the **Policyholder** terminates; or
4. the **Insured** attains age sixty-five (65).

For purposes of this rider only, the following additional definition applies:

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**.

Total Disability (Totally Disabled) means disability that:

1. prevents an **Insured** from performing the material and substantial duties of his or her occupation, or any occupation for which he or she is qualified by reason of education, training, or experience immediately prior to the **Covered Accident**; and
2. requires the **Continuous Care** and treatment of a **Physician**.

To apply for this waiver, the **Policyholder** shall notify **Us** in writing of the **Insured's Total Disability** and request a Waiver of Premium Form and a Disability Claim Form. These forms must be completed by the **Policyholder**, the **Insured** and the attending **Physician**, and mailed to the Claims Department, Zurich American Insurance Company, to the Claims Reporting address as set forth in the Schedule.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2019 Attached to and forming a part of **Policy** No. GPA 0214266

Signed for by Zurich American Insurance Company:

Mark E. Knipfer

January 1, 2019

President Date

SANCTIONS EXCLUSION ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED

Notice to Wisconsin Policyholders/ Certificateholders

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problems.

Zurich North America
Customer Inquiry Center
1299 Zurich Way
Schaumburg, Illinois 60196-1056
1-800-382-2150

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

Privacy Notice

We Take Important Steps to Protect the Personal Information We Collect About You

Dear Customer: ***rev. October 2016***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information we collect about you and what we do with that information. This Privacy Notice describes the nonpublic personal information we collect about you and how we handle the information as it relates to individuals who either own or are covered by insurance we issue, or who use other financial products or services we provide.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION

Why are you receiving this Notice?	Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company.

What types of Information do we collect?	The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include: • Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information; • Information about your transactions with the Company and its affiliates; • Information about your claims history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property; and • Information we receive from a consumer reporting agency, such as a credit report. When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.

What do we do with the nonpublic personal information we collect?	WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING).

Reasons we may share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
For our everyday business purposes – to affiliates and non-affiliates to process your transactions, administer insurance coverage, products or services, maintain your account and report to credit bureaus	Yes	No
For our marketing purposes or for joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – creditworthiness	No	No
For our affiliates to market to you	Yes	No
For non-affiliates to market to you	No	We don't share

Collecting and safeguarding information	
How often does the Company notify me about their practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision.
Why and how does the Company collect my nonpublic personal information?	We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from: • Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income. • Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc. • Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What nonpublic personal information does the Company disclose?	We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?".

How does the Company safeguard my nonpublic personal information?	Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once in writing, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW

Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: • Processing transactions, mailing and auditing services • Administering insurance coverage, product, services or claims • Providing information to credit bureaus • Protecting against fraud • Responding to court/governmental orders or subpoenas and legal investigations • Responding to insurance regulatory authorities
Affiliates	Financial or nonfinancial companies related by common ownership or control. • *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.*

Non-affiliates	Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services. • *Company does not share information with non-affiliates to market to you*.
Joint marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you. • *Company does not jointly market.*

Changes to this Privacy Notice; contact us	We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes. If you have any questions about your contract with us, you should contact your agent. If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

This Privacy Notice is sent on behalf of the following affiliated companies:

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company").